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Medical Malpractice Liability Reform: S. 354, 109th Congress

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Summary

S. 354, 109th Congress, would preempt state law regarding some aspects of medical malpractice liability, and liability for defective medical products, including drugs. It would not, however, preempt any state law that imposes greater procedural or substantive protections for health care providers, health care organizations, or sellers of medical products, from liability. In medical malpractice and defective medical products suits, S. 354 would, among other things, impose caps on noneconomic and punitive damages (but only in states with no caps or higher caps), eliminate joint and several liability, abolish the collateral source rule, limit lawyers' contingent fees, enact a federal statute of limitations, and provide for periodic payment of future damages. This report will be updated if and when Congress takes action with respect to S. 354.

Preemption of State Laws

Medical malpractice suits are governed by state law, but, because they affect interstate commerce, the U.S. Constitution would permit Congress to regulate them and to preempt state laws that regulate them. S. 354, 109th Congress, the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2005, or the HEALTH Act of 2005, would impose federal standards on some aspects of medical malpractice suits, but would leave other aspects to continue to be governed by state law.[1] Actually, S. 354 would apply to all "health care liability claims," which it defines to include not only medical

[1] S. 354 is similar to H.R. 5, 109th Congress, which the House passed without amendment on July 28, 2005. H.R. 5 is examined in CRS Report RS22054, *Medical Malpractice Liability Reform: H.R. 5, 109th Congress*, by (name redacted). The major differences between H.R. 5 and S. 354 is that S. 354 would (1) abolish the collateral source rule when applicable law does not allow for subrogation, (2) include no special protections for FDA-approved products, (3) establish qualifications for expert witnesses, and (4) preempt state caps on non-economic and punitive damages when such caps are higher than the bill's.

malpractice suits, but product liability suits that allege injuries resulting from defective medical products, which "means a [defective] drug or device intended for humans."[2]

This report will summarize the main provisions of S. 354, and will do so not in the order of the bill's sections, but in the order of the following subjects that the bill addresses: (1) cap on noneconomic damages, (2) standard for and cap on punitive damages, (3) limiting joint and several liability, (4) abolishing the collateral source rule, (5) limiting lawyers' contingent fees, (6) creating a federal statute of limitations, (7) periodic payment of future damages, and (8) expert witnesses. Another CRS report, without making reference to any particular legislation, discusses these same subjects in the same order, explaining the legal concepts each involves (in greater depth than the present report does) and offering pros and cons of each.[3]

Even with respect to those aspects of medical malpractice suits on which S. 354 would impose federal standards, S. 354 would not preempt every state law. It would not preempt any state law "that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care providers, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product from liability, loss, or damages than those provided by this act" (§ 11(c)(2)(A)). In addition, its caps on noneconomic and punitive damages would preempt only state caps that are higher than the bill's (§ 11(b)(2)).[4]

(1) Cap on Noneconomic Damages

S. 354 (§ 5(b)) would impose a $250,000 cap on noneconomic damages in any health care lawsuit, "regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence." As noted above, this cap would apply only in states that have no cap or a higher cap.[5]

Economic damages refer to monetary losses that result from an injury, such as medical expenses, lost wages, and rehabilitation costs; S. 354 would not cap economic damages. Noneconomic damages consist primarily of damages for pain and suffering. Both economic and noneconomic damages are compensatory damages, as opposed to punitive damages.

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[2] The phrase "medical malpractice" in this report, when used in reference to S. 354, should be read to include all "health care liability claims."

[3] CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, by (name redacted).

[4] S. 354 provides that it would preempt higher caps, and says nothing about whether it would preempt lower caps. One might argue that the bill therefore would preempt lower caps because the Supremacy Clause of the Constitution (Art. VI, cl. 2) provides that federal laws shall preempt state laws. But the better reading appears to be that the bill's expressly preempting higher caps evinces an intention not to preempt lower caps.

[5] S. 354 (§ 5(c)) provides that, for purposes of applying the $250,000 cap, "future noneconomic damages shall not be discounted to present value." This apparently means that, if a jury awards, say, $260,000 in future noneconomic damages, and such amount could be paid in the form of an annuity that costs $240,000, the higher figure would control, and the future noneconomic damages would be reduced to $250,000, not to $240,000.

(2) Standard for and Cap on Punitive Damages

S. 354 (§ 8(a)) provides that punitive damages may be awarded if otherwise permitted by state law, if the claimant proves "by clear and convincing evidence" that the defendant "acted with malicious intent to injure the claimant, or . . . deliberately failed to avoid unnecessary injury that [the defendant] knew the claimant was substantially certain to suffer." S. 354 would thus preempt state law regarding the burden of proof and standard for awarding punitive damages, except in states that provide greater protection for defendants.[6]

S. 354 (§ 8(b)(2)) would also impose a cap on punitive damages of $250,000 or two times the amount of *economic* (not of all compensatory) damages awarded, whichever is greater. As with S. 354's cap on noneconomic damages, the cap on punitive damages would apply only in states that have no cap or a higher cap.

S. 354 (§ 8(c)) provides: "A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug or device (including blood products) approved by the Food and Drug Administration shall not be named as a party to a product liability lawsuit invoking such drug or device . . . ." This means that doctors and pharmacists could not be held liable for prescribing or dispensing a defective drug or device. They could still be held liable for negligently prescribing or dispensing a non-defective drug or device, as an action alleging such negligence would not be a product liability lawsuit.

(3) Limiting Joint and Several Liability

S. 354 (§ 5(d)) would eliminate joint and several liability in medical malpractice suits. Joint and several liability is the common-law rule that, if more than one defendant is found liable for a plaintiff's injuries, then each defendant may be held 100 percent liable. With joint and several liability, the plaintiff may not recover more than once, but may recover all his or her damages from fewer than all liable defendants, with any defendant who pays more than its share of the damages entitled to seek contribution from other liable defendants.

The main argument for eliminating joint and several liability is that it allows a plaintiff to recover his entire damage award from a "deep pocket" defendant who was only minimally liable. The main argument for retaining joint and several liability is that it is preferable for a wrongdoer to pay more than its share of the damages than for an injured plaintiff to recover less than the full compensation to which he is entitled.

(4) Abolishing the Collateral Source Rule

The collateral source rule is the common-law rule that allows an injured party to recover damages from the defendant even if he is also entitled to receive them from a third party (a "collateral source"), such as a health insurance company, an employer, or the government. To abolish the collateral source rule would be to allow or require courts

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[6] *See* CRS Report RL31721, *Punitive Damages in Medical Malpractice Actions: Burden of Proof and Standards for Awards in the Fifty States*, by (name redacted) and Ea Alexandria Rainson.

to reduce damages by amounts a plaintiff receives or is entitled to receive from collateral sources.

Often a collateral source, such as a health insurer or the government, has a right of subrogation against the tortfeasor (the person responsible for the injury). This means that the collateral source takes over the injured party's right to sue the tortfeasor, for up to the amount the collateral source owes or has paid the injured party. Though the collateral source rule may enable the plaintiff to recover from both his insurer and the defendant, the plaintiff, if there is subrogation, must reimburse his insurer the amount it paid him. If the collateral source rule were eliminated, then the defendant would not have to pay the portion of damages paid by a collateral source, and the collateral source would apparently not be able through subrogation to recover the amount it paid the plaintiff. In the medical malpractice context, therefore, eliminating the collateral source rule would benefit liability insurers at the expense of health insurers and other collateral sources.

S. 354 (§ 7(a)) provides: "The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits)." This provision would not apply, however, if the collateral source "has a right of recovery by reimbursement or subrogation . . . ." S. 354 does not specify how the courts should determine the amount of insurance premiums paid to obtain the collateral source benefits; perhaps one year's premium would be found appropriate.

(5) Limiting Lawyers' Contingent Fees

A contingent fee is one in which a lawyer, instead of charging an hourly fee for his services, agrees, in exchange for representing a plaintiff in a tort suit, to accept a percentage of the recovery if the plaintiff wins or settles, but to receive nothing if the plaintiff loses. Payment is thus contingent upon there being a recovery. Plaintiffs agree to this arrangement in order to afford representation without having to pay anything out-of-pocket. Lawyers agree to it, despite the risk of not being compensated, because the percentage they receive if they win or settle — usually from 33⅓ to 40 percent — generally amounts to more than an hourly fee would.

S. 354 (§ 5) would impose a cap with a sliding scale in medical malpractice cases: 40% of the first $50,000 the plaintiff recovered, 33⅓% of the next $50,000, 25% of the next $500,000, and 15% of any additional amount.

(6) Creating a Federal Statute of Limitations

The statute of limitations — the period within which a lawsuit must be filed — for medical malpractice suits under state law is typically two or three years, starting on the date of injury. Sometimes, however, the symptoms of an injury do not appear immediately, or even for years after, malpractice occurs. Many states therefore have adopted a "discovery" rule, under which the statute of limitations starts to run only when the plaintiff discovers, or in the exercise of reasonable diligence should have discovered, his injury — or, sometimes, his injury and its cause.

S. 354 (§ 4) provides that "the time for the commencement of a health care lawsuit shall be three years after the date of manifestation of injury or one year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first." However, "the time for commencement of a health care lawsuit shall not exceed three years after the date of manifestation of injury unless the tolling of time was delayed as a result of — (1) fraud; (2) intentional concealment; or (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person."[7]

This provision, rather than imposing a time limitation that begins on the date of injury or on the date of discovery of the injury, would cut off the right to sue upon the earlier of two different periods — three years and one year — that begin, respectively, on the date of manifestation of injury and discovery of the injury. S. 354 defines neither term, but, commenting on a substantively identical provision in its report on H.R. 5, 108th Congress, the House Committee on Energy and Commerce explained the former term: "The term 'manifestation of injury' means the injury has become reasonably evident. Thus, if someone unknowingly receives tainted blood, 'manifestation of injury' is not the date of receiving the blood. Instead, it is the date on which adverse symptoms become reasonably evident."[8]

The discovery of the injury, then, would apparently occur on the date that the patient learns that his blood is tainted, which date may not occur until after "manifestation of injury." Suppose that medical tests reveal the tainted blood one year after the plaintiff experienced his first symptoms. There would still be two years to run on the three-year manifestation period, but the plaintiff would apparently have to sue within one year of discovering that his blood is tainted — even if it takes more than one year to learn that his blood is tainted as a result of a transfusion. A patient could also apparently discover his injury, perhaps through a routine medical test, before symptoms become manifest, and, again, the one-year discovery period would apparently apply.

S. 354 has a separate period of limitations for minors: "An action by a minor shall be commenced within three years from the date of the alleged manifestation of injury except that if such minor is under the full age of six years, such action shall be commenced within three years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period . . . ."

It is not clear whether the above time limitations are, strictly speaking, statutes of limitations. (S. 354 does not call them that.) A statute of limitations is typically an affirmative defense, which means that the defendant must raise it; if the defendant fails to raise it, then the plaintiff may sue regardless of how much time has passed.[9] S. 354, by contrast, could be interpreted to place the burden of proof on the plaintiff to show that his injury occurred within the time period allowed.

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[7] By "the tolling of time" the bill apparently means that the statute would be tolled — i.e., the time period would not start to run — if the plaintiff had been unable to discover his injury because of fraud, intentional concealment, or the presence of a foreign body.

[8] H.Rept. 108-32, Part 2 (Mar. 11, 2003) at 28.

[9] *See*, e.g., Federal Rule of Civil Procedure 8(c).

(7) Periodic Payment of Future Damages

Traditionally, damages are paid in a lump sum, even if they are for future medical care or future lost wages. In recent years, however, "attorneys for both parties in damages actions have occasionally foregone lump-sum settlements in favor of structured settlements, which give the plaintiff a steady series of payments over a period of time through the purchase of an annuity or through self-funding by an institutional defendant."[10]

S. 354 (§ 9) provides:

> In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000, is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Law.

Though this provision states that an award of future damages shall not be reduced to present value to determine whether it equals or exceeds the $50,000 minimum necessary for a party to require the court to order periodic payments, it does not state whether the amount of the award of future damages would be converted to present value. Not to require such conversion "could be a very major change, significantly reducing awards, if it is intended to allow a defendant to pay, for example, a $1 million award over a 10-year period at $100,000 a year. On the other hand, if it requires the jury award to be converted into present value terms — an annuity with a present value of $1 million — the reform doesn't mean that much; as a practical matter, the defendant would be paying the same amount as before."[11] The defendant, that is, would have to spend $1 million for an annuity that, as it earned interest over the years of its distribution, would yield the plaintiff more than $1 million. Had the defendant paid the plaintiff a lump sum of $1 million, then the plaintiff could have purchased that same annuity.

(8) Expert Witnesses

S. 354 (§ 6(c)) provides, in part: "No individual shall be qualified to testify as an expert witness concerning the issue of negligence in any health care lawsuit" unless he is appropriately credentialed, typically treats the condition at issue, and demonstrates that he is "substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident."

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[10] Annotation, *Propriety and Effect of "Structured Settlements" Whereby Damages are Paid in Installments Over a Period of Time, and Attorneys' Fees Arrangements in Relation Thereto*, 31 ALR4th 95, 96.

[11] Victor Schwartz, *Doctors' Delight, Attorneys' Dilemma*, Legal Times, Health-Care Law Supplement (Feb. 28, 1994) at 30.